

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in the event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
01333 CERTIFICATE OF DEATH 01293																	
1. PLACE OF DEATH a. COUNTY Somerset				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Princess Anne				b. COUNTY Somerset													
c. LENGTH OF STAY IN 1B Life Time				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS													
3. NAME OF DECEASED (Type or print)			First Lottie	Middle Doane	Last Ballard	4. DATE OF DEATH	Month I	Day 3	Year 1966								
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. OATE OF BIRTH	9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	IF UNDER 1 YEAR Months Days Hours Min.								
Female		Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/4/04	61 yrs.	House Work	Princess Anne, Md	USA									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY House Wife				11. BIRTHPLACE (County & State, or foreign country) Princess Anne, Md				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Azraim Doane				14. MOTHER'S MAIDEN NAME Mary Hayward				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
																Nennie Boomer Princess Anne, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE																	
441X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) MALIGNANT HYPERTENSION												24 mos.					
DUE TO (c) CARDIO-RENAL ART. Sclerosis.												UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/6 , 19 66 , to 1/3 , 19 66 , that (I) (we) last saw the deceased alive on 1/2 19 66 , and that death occurred at 4 AM , from the causes and on the date stated above.												22b. DATE SIGNED 1/4/66					
22a. SIGNATURE Murphy A. Baron												22b. DATE SIGNED 1/4/66					
22c. PHYSICIAN'S NAME (Type)				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS Pocomoke, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/8/66				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt Hope				23d. LOCATION (City, town or county) (State) Princess Anne, Maryland					
24. FUNERAL DIRECTOR William H. James Jr Princess Anne, Md								25a. REC'D BY REGISTRAR JAN 11 1966				25b. REGISTRAR'S SIGNATURE Charles Judge					

4

REFERENCES AND NOTES

4. $\lambda = 10 \text{ cm}^2 - 10 \text{ cm}^2$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01334

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01294

1. PLACE OF DEATH
a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Crisfield

c. LENGTH OF STAY IN 1b

10 Days

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland

b. COUNTY Somerset

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

McCready Memorial Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Crisfield

19-1

d. STREET ADDRESS

Byrdtown

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First William Middle Arthur Last Byrd

4. DATE
OF
DEATHMonth Jan. Day 10 Year 66
19

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED
WIDOWED NEVER MARRIED
 DIVORCED

8. DATE OF BIRTH

June 19, 1896

9. AGE (In years
last birthday)

69 yrs.

10. UNDER 1 YEAR

Months 0
Days 011. UNDER 24 HRS.
Hours 0
Min. 010a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Waterman

10b. KIND OF BUSINESS OR
INDUSTRY

Seafood

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

Crisfield, Md.

U.S.A.

13. FATHER'S NAME

William Byrd

14. MOTHER'S MAIDEN NAME

Betty Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

World War I 218-09-3719

17. INFORMANT

Mrs. Anna Lee Byrd, Crisfield, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Massive pulmonary effusion (rt.)

INTERVAL BETWEEN
ONSET AND DEATH10 days -
10 days -
15 years -241X
Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO Pneumococcal effusion

(b) Chronic Asthma -

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1966, to Jan. 10, 1966, that (I) (we) last saw the deceased alive on Jan. 10, 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Sarah M. Peyton

M.D. ATTENDING PHYS.

MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

1/11/66

22c. PHYSICIAN'S
NAME (Type)

Dr. S. M. Peyton

22d. ADDRESS

Main St. Crisfield, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Jan. 13, 1966

23c. NAME OF CEMETERY OR CREMATORI

American Legion Cemetery

23d. LOCATION (City, town or county) (State)

Crisfield, Md.

24. FUNERAL DIRECTOR

Bradshaw & Sons

ADDRESS

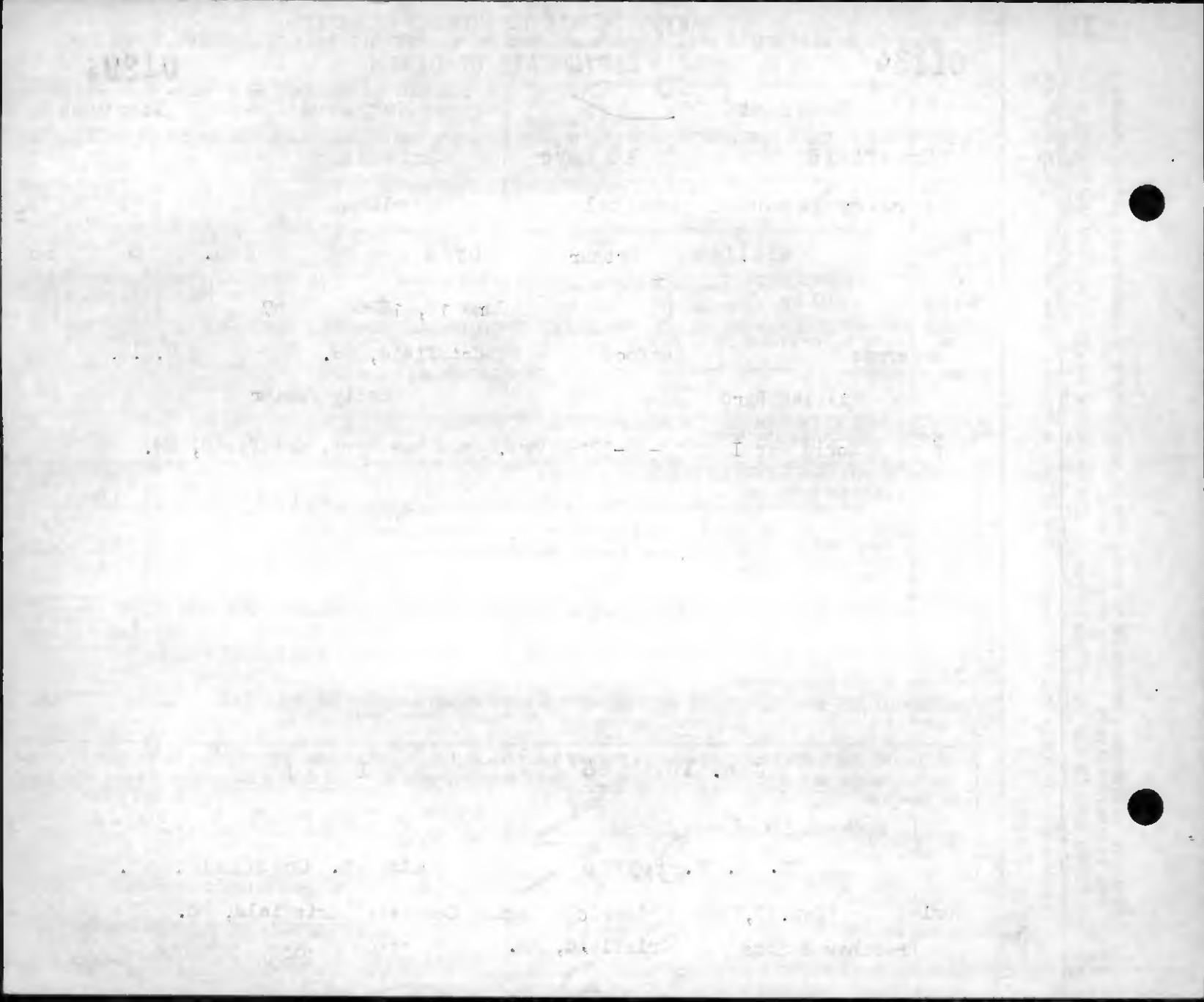
Crisfield, Md.

25a. REC'D BY REGISTRAR

JAN 18 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form REC-3. Pages 5 may be used as a burial/transit permit. File pages 1 and 2 with the State Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01335

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01295

1. PLACE OF DEATH
a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wenona

c. LENGTH OF STAY IN 1b

10 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

at Home

3. NAME OF
DECEASED
(Type or print)

First
James

Middle
L

Last
Corbin

4. DATE
OF
DEATH

Jan 1

Day
Year
1966

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Dec 12, 1906

9. AGE (in years
last birthday)

59

10. IF UNDER 1 YEAR

Months
Days

IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seafood

10b. KIND OF BUSINESS OR INDUSTRY

Waterman

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William L Corbin

14. MOTHER'S MAIDEN NAME

Sidennia Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs Esther Corbin, Wenona, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH
minutes

4201

DE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
(e), stating the underlying
cause last.

(b)

DE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES

NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

Not Whila
al work al work

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

Somerset 1-3-65

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Burial

1-4-66

Church Cemetery

Ewell

Smith Island, Md.

23. FUNERAL DIRECTOR

R. G. Webster

ADDRESS

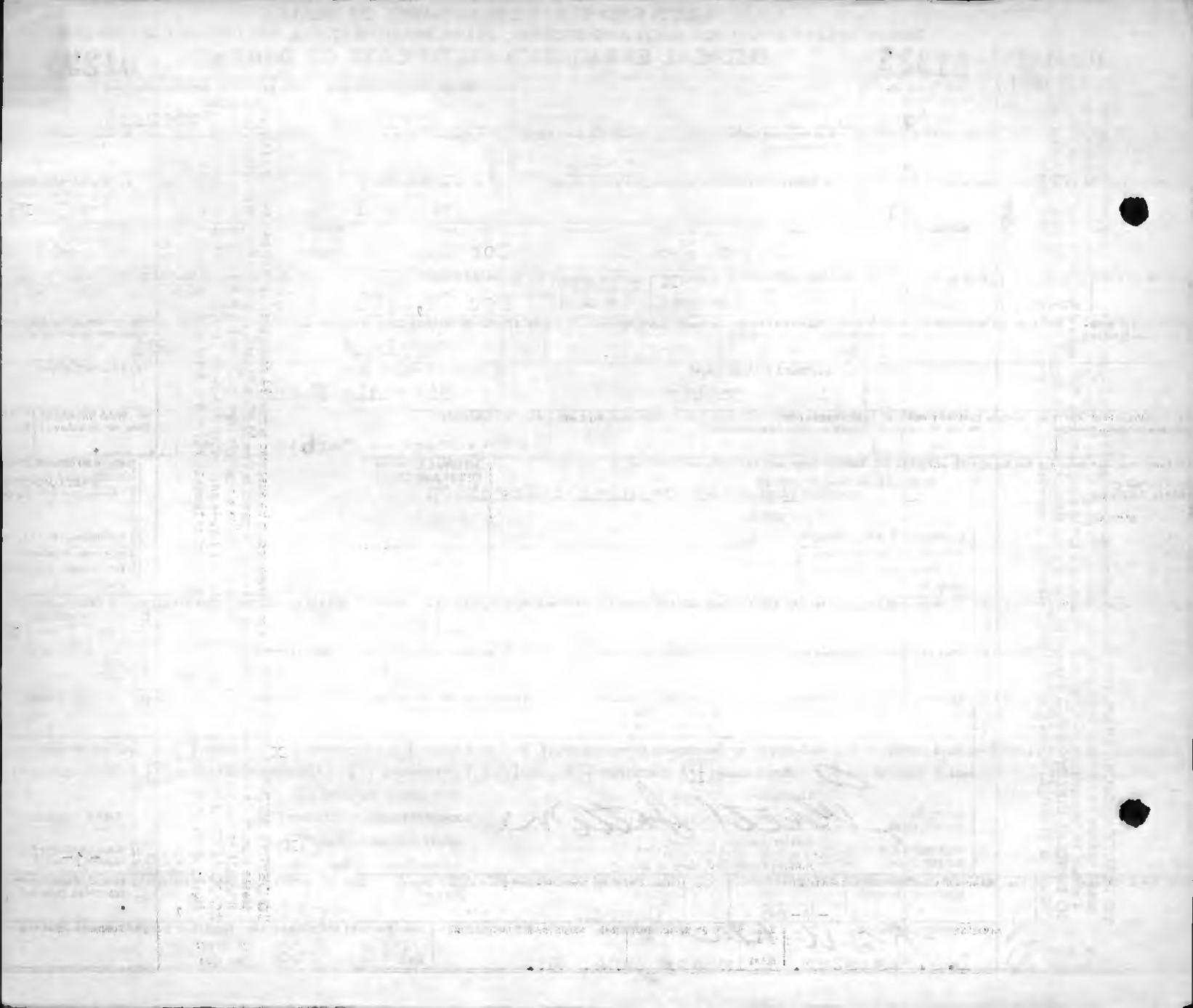
L. G. Webster, Princess Anne, Md.

24a. REC'D BY REGISTRAR

JAN 5

1966

24b. REGISTRAR'S SIGNATURE
Charles Judd



1

FOR STATE
HEALTH DEPTMARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01336

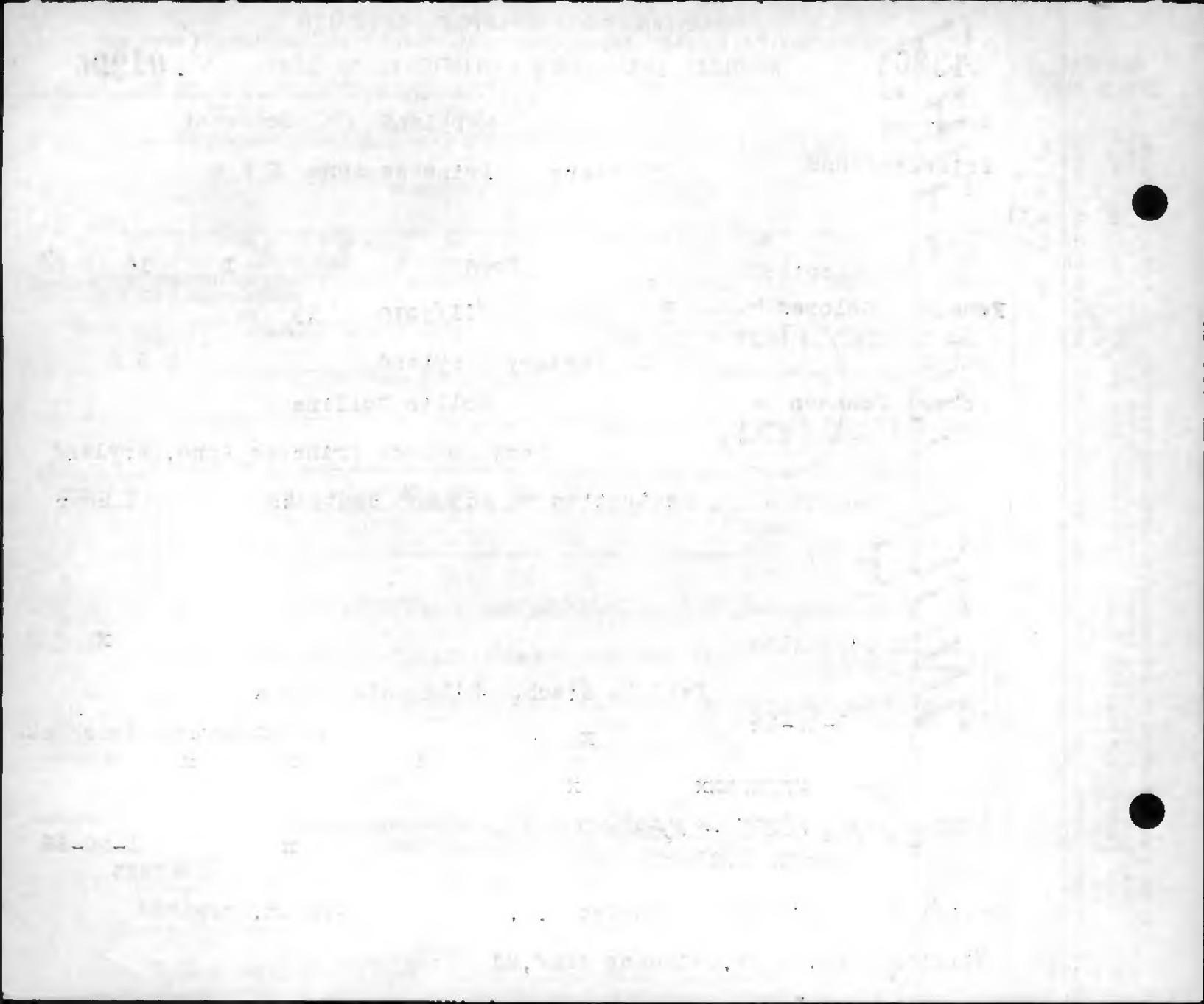
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01296

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louise		First Ford	Middle Last I
4. DATE OF DEATH 16 19 66	Month I	Day 16	Year 1966
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/II/1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	9. AGE (In years last birthday) 55 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	13. FATHER'S NAME Robert Johnson
14. MOTHER'S MAIDEN NAME Mollie Collins	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Mary Johnson Princess Anne, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration of stomach contents		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) brain contusion			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.) fell in ditch, while going home	
20c. TIME OF INJURY Month, Day, Year 1 Hour e.m. 1-16-66 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) (County) (State) Princess Anne Somerset Md		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: homicide , Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Everett Sutter MD</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Everett Sutter MD		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Somerset			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/66	23c. NAME OF CEMETERY OR CREMATORIAL Christ M.E.
23d. LOCATION (City, town or county) (State) Coston, Maryland		25a. REC'D BY REGISTRAR JAN 26 1966	
24. FUNERAL DIRECTOR William H James Jr. Princess Anne, Md		25b. REGISTRAR'S SIGNATURE <i>planned</i>	
VR AISM 5M 1/65		DATE	

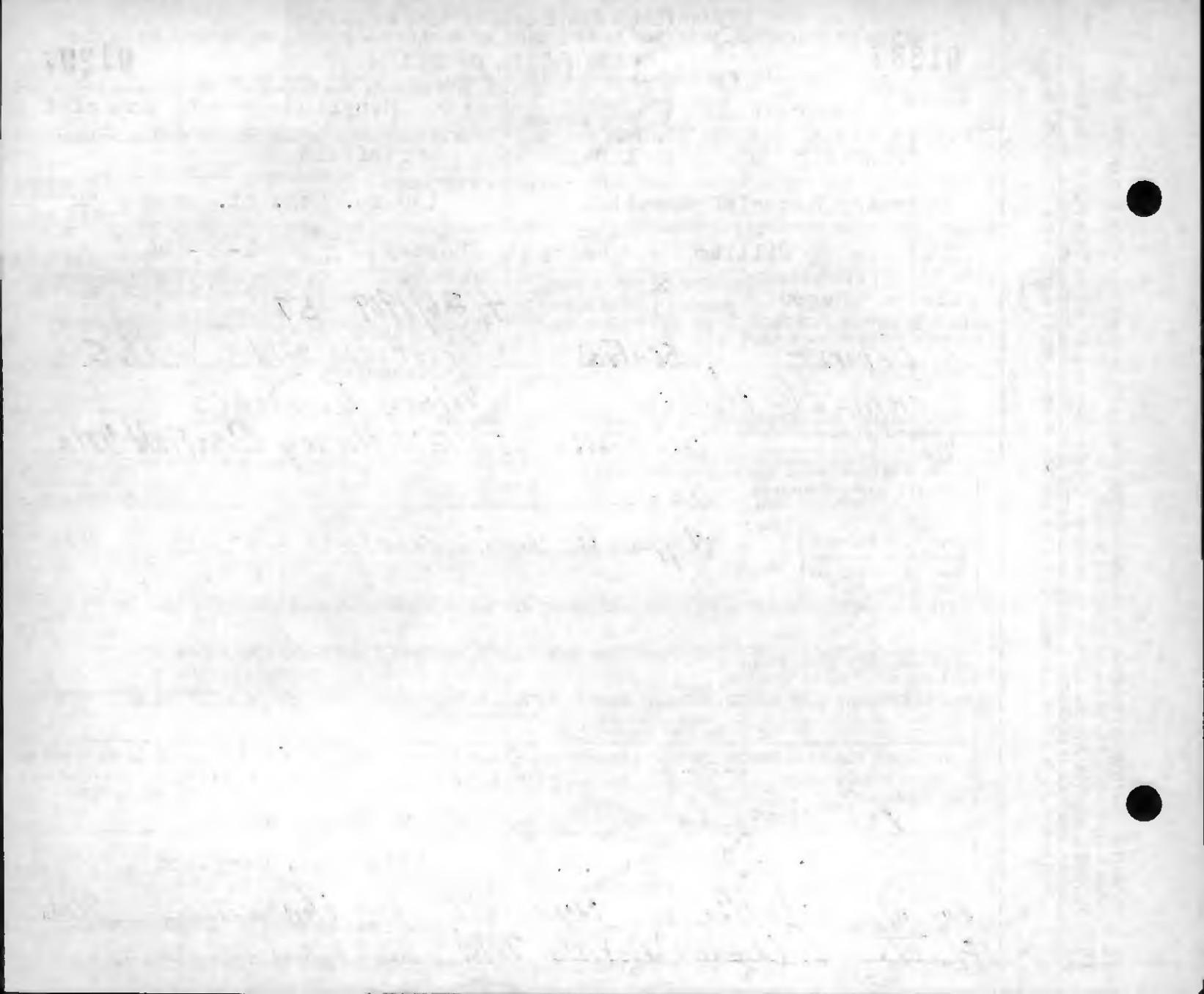


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all events, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
Item #9 Film #0333 2/1/66 01297														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
Somerset			a. STATE Maryland b. COUNTY Somerset											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			c. LENGTH OF STAY IN 1D 1 Day											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First William	Middle Henry	Last Horsey	4. DATE OF DEATH 1-20-66	Month 1	Day 20	Year 66					
5. SEX Male			6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/26/1909	9. AGE (In years last birthday) 57 56 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		11. BIRTHPLACE (County & State, or foreign country) Crisfield Md.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME SAMUEL HORSEY			14. MOTHER'S MAIDEN NAME MARY E. JONES			Address Edith F. Horsey Crisfield Md.								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-01-6563			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Hyper tension; Malignant			INTERVAL BETWEEN ONSET AND DEATH 6 mos.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 1-20-66, 1966, to 1-20-66, 1966, that (I) (we) last saw the deceased alive on 1-20-66, 1966, and that death occurred at 5A M, from the causes and on the date stated above.			22a. SIGNATURE R. E. Roberts, M.D.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS Crisfield, Maryland			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/24/66			23c. NAME OF CEMETERY OR CREMATORIAL HOPEWELL		
24. FUNERAL DIRECTOR Franklin E. Ward Crisfield Md.			ADDRESS			23d. LOCATION (City, town or county) Hopewell Md.			25a. REC'D BY REGISTRAR DATE JAN 24 1956			25b. REGISTRAR'S SIGNATURE F. Franklin E. Ward Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01338

01295

1
FOR STATE
HEALTH DEPT.4
TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FURNITURE: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lower Fairmount		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lower Fairmount		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount, Maryland	
3. NAME OF DECEASED (Type or print) Felix		d. STREET ADDRESS Box 77	
4. DATE OF DEATH Last Jones 1 29 66		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-1889	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Oriole, Md		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Richard Jones		14. MOTHER'S MAIDEN NAME Susan Mason	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1918-1919 216-07 7586	
17. INFORMANT Ethel Jones, Fairmount Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN DEATH MINUTES	
DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)			
DUE TO (d) (e), stating the underlying cause last. (f)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE-SIGNED			
ACTUAL SIGNATURE <i>Everett Sutter</i>		EXAMINER'S NAME (Type) Everett C. Sutter MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-66	
22c. NAME OF CEMETERY OR CREMATORIUM Centennial		22d. LOCATION (City, town, or county) Fairmount, Md.	
23. FUNERAL DIRECTOR Anthony E Ward, Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR Feb 7 1966		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY INSPECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.



1
FOR STATE
HEALTH DEPT.

01339

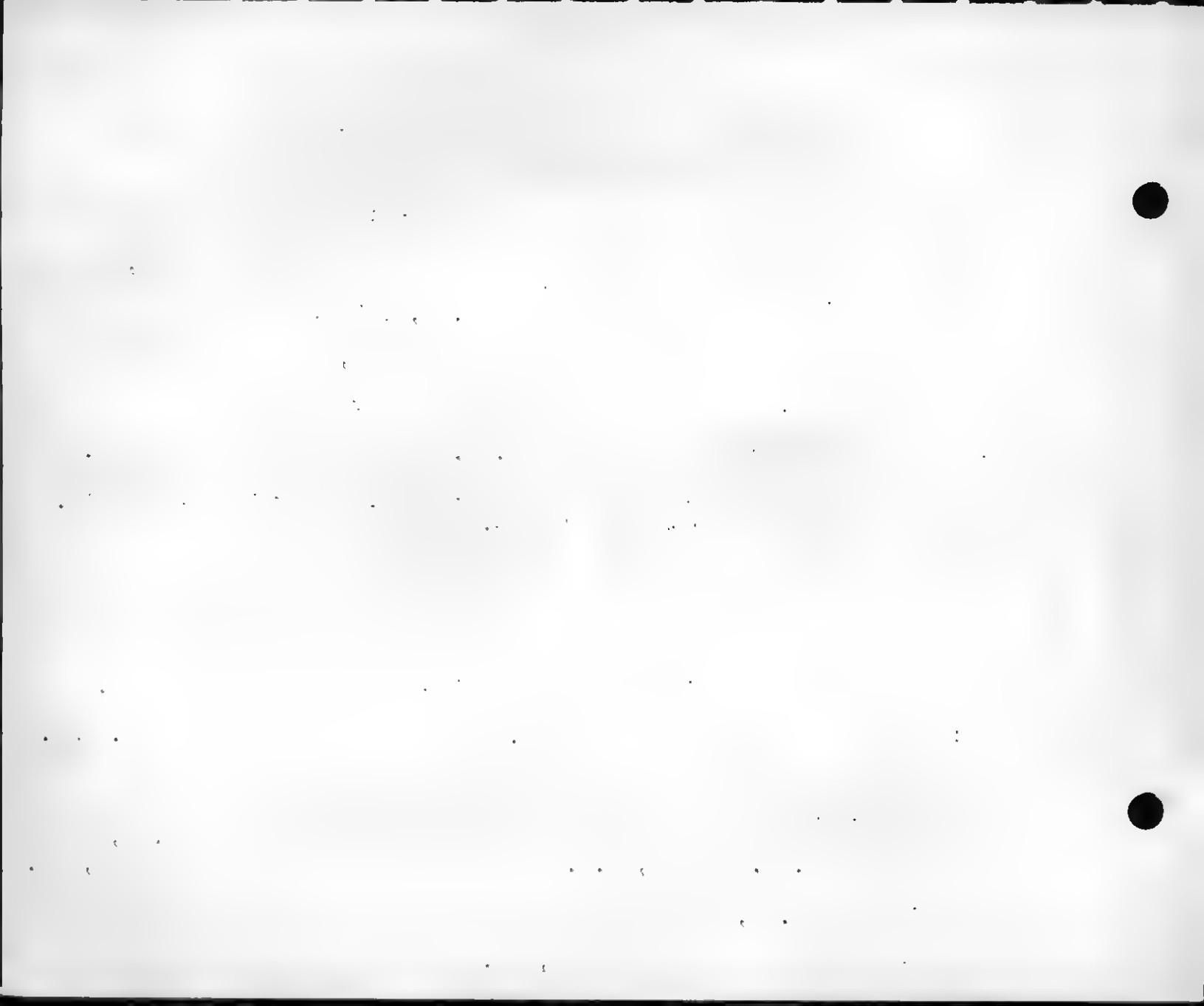
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12825

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE		
Somerset MARYLAND		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		
Crisfield		Lifetime		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?		
McCreedy Memorial Hospital		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle BAYNE	Last MORGAN	
4. DATE OF DEATH	Month January	Day 31,	Year 19 66	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 16, 1939 26 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		
Student	College	Crisfield, Maryland		
12. CITIZEN OF WHAT COUNTRY	USA			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
Barney Morgan	Sally Evelyn Dize			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
Yes 1958/1962		Mrs. S. Evelyn Morgan, Same as 2.abcd		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal injuries; Laceration of liver 35 min. DUE TO with hemorrhage.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Thrown from sled into path of oncoming car.		
20c. TIME OF INJURY Month, Day, Year Hour XX 9:30 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 667	20f. (City or town) (County) (State) Crisfield Som. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>C. G. Rawley</i>	EXAMINER'S NAME (Type) C. G. Rawley, M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED Feb. 4, 1966	
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	23d. LOCATION (City, town or county) (State) Crisfield, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 4, 1966	23c. NAME OF CEMETERY OR CREMATRY Sunnyridge Cemetery Crisfield Maryland	
24. FUNERAL DIRECTOR Bradshaw & Sons		ADDRESS Crisfield, Md.	25a. REC'D BY REGISTRAR FEB 8 1966	25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01340

CERTIFICATE OF DEATH

01299

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main St.				d. STREET ADDRESS Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) OMAR		First	Middle	Last	4. DATE OF DEATH Jan. 17 1966	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1898	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer		10b. KIND OF BUSINESS OR INDUSTRY New & Used Cars		11. BIRTHPLACE (County & State, or foreign country) Oriole, Somerset County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry B. Phoebus				14. MOTHER'S MAIDEN NAME Emily Williams				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) Yes		16. SOCIAL SECURITY NO. Worked War II		17. INFORMANT Mrs. Florence Phoebus, Same as 1 a,b,d above		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x		DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)		Cerebral Thrombosis				
DUE TO cause (a), stating the underlying cause last. (c)				Hypertension				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Feb 11 th , 1964 to Jan 17 1966 that (I) (we) last saw the deceased alive on Jan 11 1966, and that death occurred at 5:20 AM, from the causes and on the date stated above.		22b. DATE SIGNED						
22a. SIGNATURE Eldon G. Marksman M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Dr. E. G. Marksman, M.D.		22d. ADDRESS Princess Anne, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Md.		
24. FUNERAL DIRECTOR Bradshaw & Sons -- Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 21 1966		25b. REGISTRAR'S SIGNATURE Charles Juice		

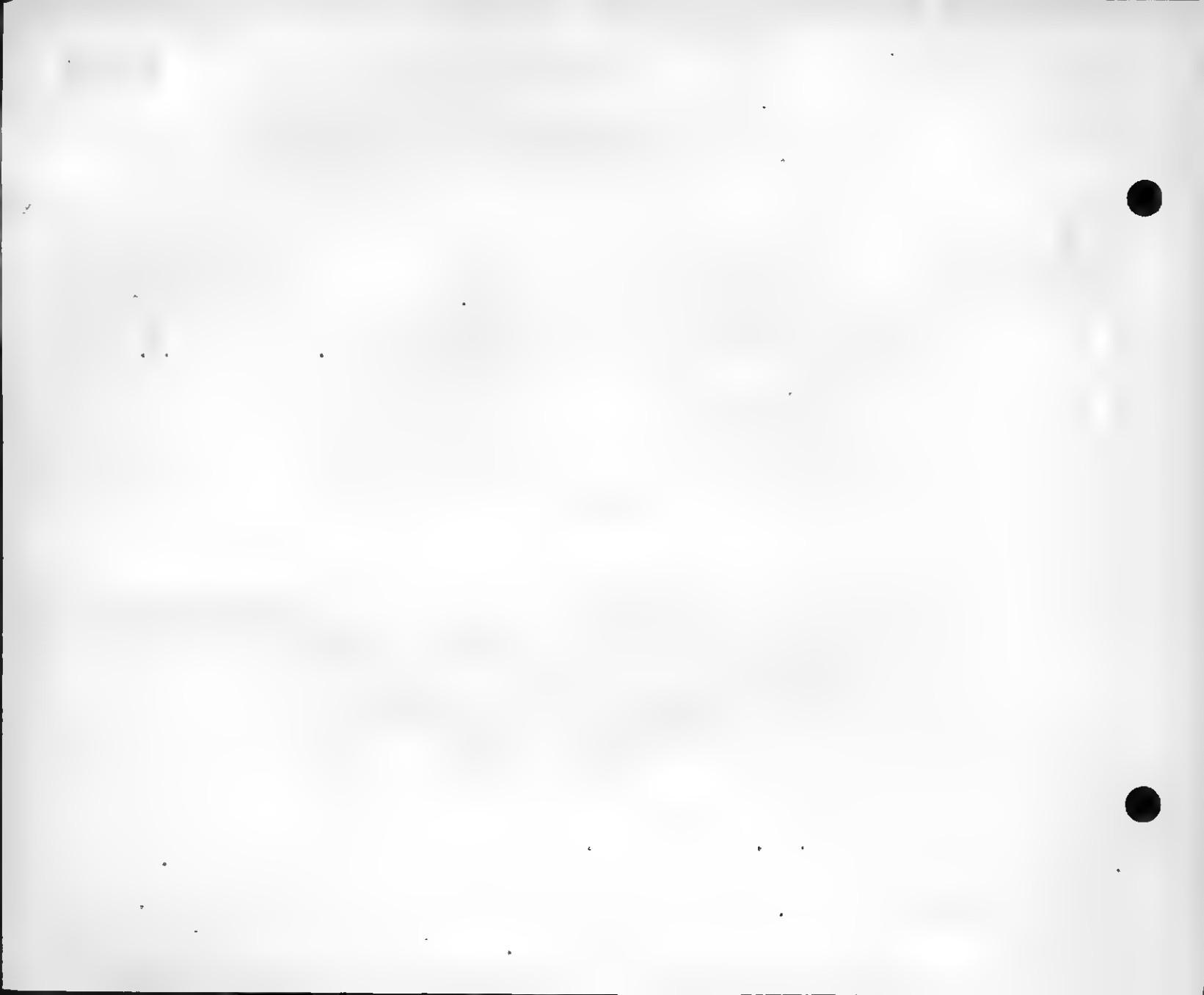
X

LII.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01341 01300											
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield, c. LENGTH OF STAY IN lb 1 day											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital											
3. NAME OF DECEASED (Type or print)	First Infant	Middle Female	Last ROSS	4. DATE OF DEATH 1/13/66	Month 1	Day 19	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1966	9. AGE (In years last birthday) 0 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Lee Ross				14. MOTHER'S MAIDEN NAME Norma Lee Bell							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Edward Lee Ross-same as 2-c,d above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 hrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crisfield, Md.		(County) Wicomico Co.		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 1-12, 1966, to 1-13, 1966, that (I) (we) last saw the deceased alive on 1-13, 1966, and that death occurred at 6:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE C. G. Rawley 22b. DATE SIGNED 1-13-66											
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, Md.		M.D. <input type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Crisfield, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Rehobeth Methodist Cemetery -- Rehobeth, Md.		23d. LOCATION (City, town or county) Rehobeth, Md.		(State)			
24. FUNERAL DIRECTOR Bradshaw & Sons -- Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

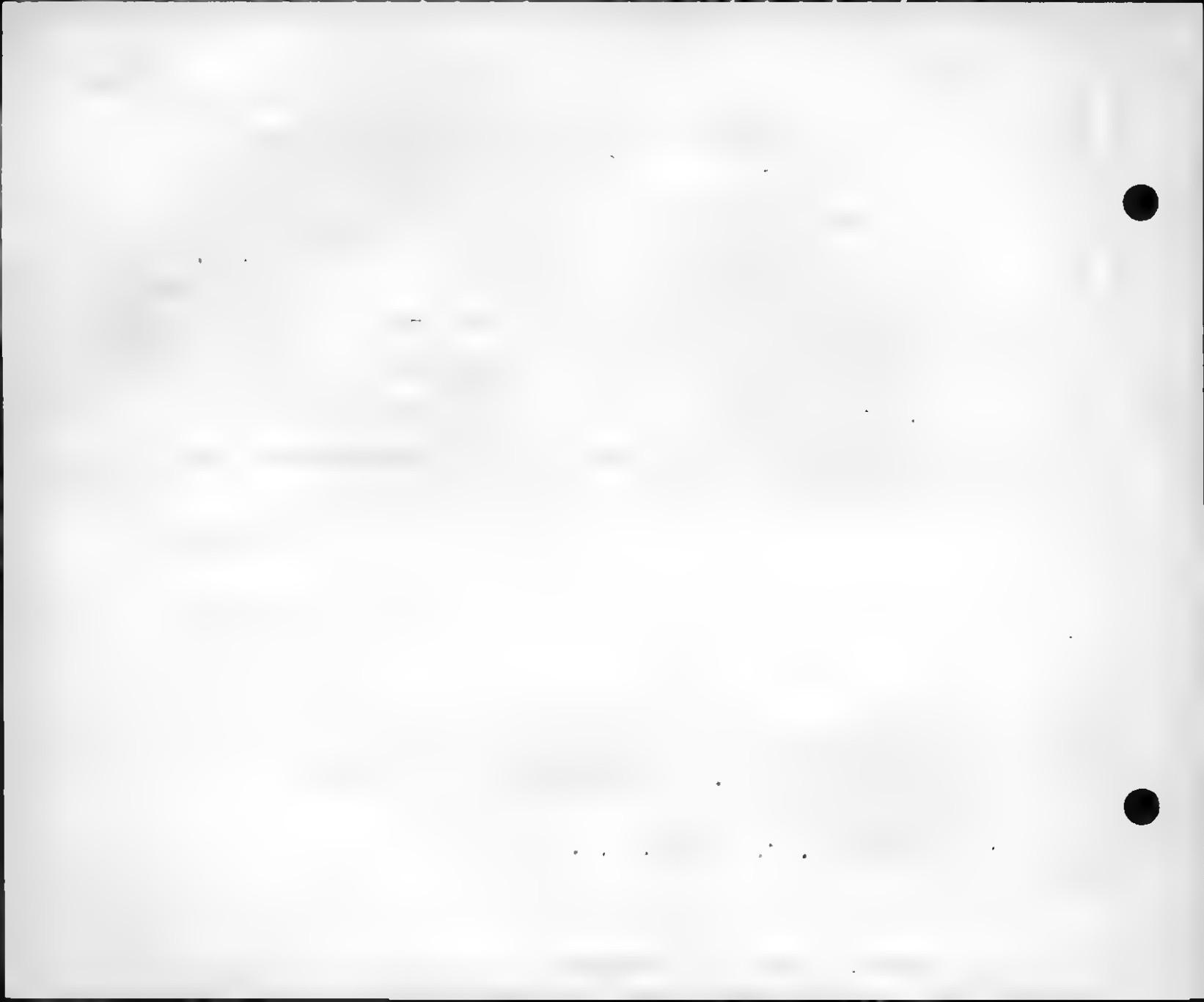
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01342

CERTIFICATE OF DEATH

02827

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield,		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Letitia	Middle 	Last Sterling
4. DATE OF DEATH Jan. 31 1966	Month Jan.	Day 31	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4-1875
9. AGE (in years last birthday) 90 yrs. Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Household	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Robert Hurley	14. MOTHER'S MAIDEN NAME Comfort Taylor	Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Olive Christy-Crisfield-Md	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. b) Hypertensive cardiac vascular disease DUE TO c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) INTERVAL BETWEEN ONSET AND DEATH 1965 1
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on Jan. 31, 1966, and that death occurred at 9:10 M, from the causes and on the date stated above.			
22a. SIGNATURE C. G. Rawley, M.D.		22b. DATE SIGNED 2/2/66	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS Crisfield, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 3-1966	23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery	23d. LOCATION (City, town or county) (State) Crisfield-Md
24. FUNERAL DIRECTOR Hinman Funeral Home Crisfield, Md	ADDRESS	25a. REC'D BY REGISTRAR FEB 8 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01301

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY Somerset MARYLAND		a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA McCready Memorial Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield	
f. STREET ADDRESS Mariners Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS First Middle MELVIN Last WARD		4. DATE OF DEATH January 30, 1966	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part Owner		10b. KIND OF BUSINESS OR INDUSTRY Bottled Gas	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank B. Ward		14. MOTHER'S MAIDEN NAME Effie C. Ward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service WW 2		16. SOCIAL SECURITY NO. 154-01-8264 17. INFORMANT Mrs. Jeanette Mrohs, Same as 2. abcd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201		INTERVAL BETWEEN ONSET AND DEATH Minutes	
(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crisfield (County) Md. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE C. G. Rawley		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/66 22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	
23. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		ADDRESS 24a. REC'D BY REGISTRAR FEB 7 1966 24b. REGISTRAR'S SIGNATURE Charles Judge	

10516

--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
Item #1b & a film #313 2/18/66 pg 01302												
1. PLACE OF DEATH a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)			
Somerset			Crisfield			Life			a. STATE Md b. COUNTY Somerset			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			
108 S. 4th St.						Crisfield			108 S. 4th St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)			First Emma Fields			Last Wilson			4. DATE OF DEATH	Month 1	Day 10	Year 1966
5. SEX F			6. COLOR OR RACE Negro			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months 87 yrs.	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY U.S.			
Retired						Bullbeggar Va.						
13. FATHER'S NAME Moses Bailey			14. MOTHER'S MAIDEN NAME Marzelina Drummond									
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT			Address Alberta Gray Crisfield Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1810 Carcinoma, bladder INTERVAL BETWEEN DUE TO Conditions, If any, which gave rise to immediate onset and death cause (a), stating the underlying cause last. (b) DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from Jan 10 1965, to Jan 10, 1966, that (I) (we) last saw the deceased alive on Jan 10 1966, and that death occurred at 2439 M, from the causes and on the date stated above.												
22a. SIGNATURE C. S. Rawley			22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) C. S. Rawley M.D.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/14/66			23c. NAME OF CEMETERY OR CREMATORIAL Asbury			23d. LOCATION (City, town or county) Crisfield (State) Md			
24. FUNERAL DIRECTOR Anthony E. Ward Crisfield Md.			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE J. Charles Judge			
						DATE JAN 17 1966						

